# HCFA LEGISLATIVE SUMMARY

JAN 17 1989

**TECHNICAL AND MISCELLANEOUS REVENUE ACT OF 1988, P.L. 100-647**

On November 10, 1988, the President signed into law H.R. 4333, the Technical and Miscellaneous Revenue Act of 1988 (P.L. 100-647). A summary of Medicare, Medicaid and other relevant provisions is attached.

As a new addition to our summary format, we have included after the Technical and Miscellaneous Revenue Act section number a reference to the amended section of the Social Security Act.

Ellen Shillinglaw
Director
Office of Legislation and Policy

# TECHNICAL AND MISCELLANEOUS REVENUE ACT OF 1988
# Public Law 100-647

## TABLE OF CONTENTS

**PART IV - PROVISIONS RELATING TO MEDICAID**

# TECHNICAL AND MISCELLANEOUS REVENUE ACT OF 1988
# Public Law 100-647

## TITLE VIII - AMENDMENTS RELATING TO SOCIAL SECURITY PROGRAMS

### Subtitle C - National Commission on Children

**Delay in Reporting Date for National Commission on Children (Section 8201, amending Section 1139)**

Current Law

- The National Commission on Children is required to study and make recommendations on health, education, income security, and tax policy affecting children and on social and support systems available to them and their families. An interim report is due September 30, 1988, and a final report March 31, 1989.

Provision

- Establishes new reporting deadlines of September 30, 1989 for the interim report, and March 31, 1990 for the final report.

Effective Date

- Upon enactment.

### Subtitle E - Medicare and Medicaid
### Part I - Provisions Relating to Part A of Medicare

**Extension of Disproportionate Share Provision (Section 8401, amending Section 1886(d))**

Current Law

- For discharges occurring before October 1, 1990, hospitals which serve a disproportionate share of low income patients receive a Medicare payment adjustment.

Provision

- The Medicare payment adjustment for disproportionate share hospitals is extended for discharges occurring before October 1, 1995.

Effective Date

- Upon enactment.

**Maintenance of Bad Debt Collection Policy (Section 8402)**

Current Law

- The Secretary is prohibited from making changes to the policy in effect on August 1, 1987 concerning Medicare payments to hospitals for bad debts associated with unpaid deductibles and coinsurance, including changes to the criteria in effect on that date concerning what constitutes a reasonable collection effort.

Provision

- Makes explicit in statute the criteria for reasonable collection efforts in effect on August 1, 1987; i.e., that reasonable collection efforts include criteria for indigency determination procedures, for record keeping, and for determining whether to refer a claim to an external collection agency.

Effective Date

- As if included in OBRA 87 (December 22, 1987).

**Application of Wage Indices in Case of Areas Affected by Section 4005(a)(1) of OBRA 87 (Section 8403, amending Section 1886(d)(8))**

Current Law

- Hospitals in certain rural counties adjacent to urban areas can be treated as if located in the urban areas for Medicare payment purposes, and their wage data then must be included in the calculation of urban wage indices.

Provision

- If including wage data from hospitals in an adjacent rural county causes a decline in the urban wage index, two wage indices will be calculated: one for the urban area and one for the adjacent rural county, which will then be treated as a separate urban area for Medicare payment purposes.

- Wage data from hospitals in rural counties adjacent to urban areas will be included in the calculation of the Statewide rural wage index if excluding this data would cause the Statewide index to decline.

- Within 60 days of enactment, the Secretary must report to Congress on legislative and administrative alternatives that would result in FY 1989 hospital payments at least as great as they would have been if hospitals in an adjacent rural county

had not been treated as if in the urban area. The Secretary's recommendations must consider alternatives that would both increase and not increase aggregate payments.

- ProPAC is required to report to Congress within nine months of enactment on the appropriate payment for hospitals affected by treating hospitals in adjacent rural counties as urban, including the appropriate treatment of their wages and related costs in computing wage indices.

Effective Date

- Hospital Wage Indices - For discharges occurring on or after October 1, 1989 and before October 1, 1991.
- HHS Report - January 9, 1989.
- ProPAC Report - August 1989.

**Demonstration Projects with Respect to Chronic Ventilator-Dependent Units in Hospitals (Section 8404)**

Current Law

- The Secretary is required, in consultation with ProPAC, to carry out up to five chronic ventilator demonstration projects of up to three years duration to review the appropriateness of classifying chronic ventilator units in hospitals as rehabilitation units eligible for cost reimbursement under Medicare.

Provision

- Requires the Secretary to initiate at least five demonstration projects to be of at least three years duration.

Effective Date

- July 1, 1988.

**Election of Personnel Policy for ProPAC Employees (Section 8405)**

Current Law

- ProPAC employees hired before December 22, 1987 (the date OBRA 87 was signed into law) are covered under the personnel policy regarding compensation, employee benefits, rights, and privileges in effect on that date. OBRA 87 provided that ProPAC employees be treated as if they were employees

of the U.S. Senate.

Provision

- ProPAC employees hired before December 22, 1987, have the option to elect either the old personnel policy or the new personnel policy enacted in OBRA 87, within 60 days of the date of enactment.

Effective Date

- Upon enactment.

## Part II - Relating to Parts A and B of Medicare

### Treatment of Certain Nursing Education Programs (Section 8411)

Current Law

- The Secretary conducts studies relating to the health care of the aged and disabled and the administration of the Medicare program. Specific studies or demonstrations are often mandated in conjunction with new provision enacted in the Medicare program.

- Medicare currently pays for the reasonable costs of nursing education programs that are directly operated by hospitals as part of an approved educational program. Medicare does not pay hospitals for nurse teaching programs sponsored by other educational institutions. As a consequence, Medicare will pay for some undergraduate, but no graduate-level nursing education.

Provision

- The Secretary must conduct five-year demonstration projects of nursing graduate education programs in five hospitals. Medicare will pay up to $200,000 each year of the hospitals' reasonable costs incurred under written agreements with educational institutions to provide educational programs that involve a substantial clinical component and lead to masters' or doctoral degrees in nursing.

  The Secretary must report to Congress on the supply and characteristics of the nurses trained under this demonstration program.

- For a three-year period, Medicare will recognize the reasonable costs of a jointly-operated undergraduate nursing education program in a hospital that:

- was paid under reimbursement demonstration waivers which expired September 30, 1985; and

- for all cost reporting periods beginning with FY 1985, has been associated with a nursing college with which it shares common directors and has incurred substantial costs related to this association.

Effective Date

- o The demonstration projects are for cost reporting periods beginning on or after July 1, 1989, and before July 1, 1994.

- o The report to Congress is due January 1, 1995.

- o The special payment provision for certain undergraduate nursing education programs applies to hospital cost reporting periods beginning in fiscal years 1989-91.

**Elimination of Waivers of 50:50 Rule for HMO Enrollment (Section 8412, amending Section 1876(f))**

Current Law

- o In order to qualify for a Medicare contract, no more than half of an HMO/CMP's members can be Medicare or Medicaid beneficiaries.

- o If an HMO/CMP establishes an affiliate or subsidiary as an independent corporation and the affiliate seeks a Medicare risk contract, it must meet the 50:50 test on its own regardless of the membership composition of the parent corporation. OBRA 87 established a statutory exception to this rule for HIP of New York, allowing them to combine enrollment in the Florida and New York plans for purposes of meeting the 50:50 test until November 1, 1992. OBRA 87 also provided an exception for Michigan Blue Care HMO Network, deeming them to meet the 50:50 test if no more that 50 percent of the total enrollment of the Blue Care Network is comprised of Medicare or Medicaid beneficiaries and no more than 20 percent of the enrollees or assignees of each HMO are Medicare beneficiaries.

Provision

- o Repeals exceptions to the 50:50 requirement enacted in OBRA 87 for HIP and Michigan Blue Care HMO Network.

Effective Date

- o Upon enactment for contracts entered into on or after that

date. Does not apply to contracts (and extensions not exceeding 90 days) in effect on the date of enactment.

**Patient Outcome Assessment Research Program (Section 8413, amending Section 1875(c)(3))**

Current Law

- The appropriation authorization for patient outcome assessment research totals $7.5 million for FY 1989. Of this amount, $5 million is authorized from the Health Insurance Trust Fund, and $2.5 million from the Supplementary Medical Insurance Trust Fund.

Provision

- The appropriation authorization is increased to a total of $10 million in FY 1989, with two-thirds authorized from the Health Insurance Trust Fund and one-third from the Supplementary Medical Insurance Trust Fund. The authorization is set at $20 million for FY 1990 and $30 million for FY 1991.

Effective Date

- Upon enactment.

**Delay in Reporting Deadline for U.S. Bipartisan Commission on Comprehensive Health Care (Section 8414)**

Current Law

- The Medicare Catastrophic Coverage Act of 1988 established a U.S. Bipartisan Commission on Comprehensive Health Care and required it to submit reports to Congress by:

  - January 1, 1989 (six months after enactment) on comprehensive long-term care services for the elderly and disabled, and

  - July 1, 1989 (one year after enactment) on comprehensive health care services for the elderly, disabled and for all other individuals.

Provision

- Extends the two report dates to six months and one year, respectively, from the date of the first act that appropriates funds for the Commission.

Effective Date

- Upon enactment.

## Part III - Provisions Relating to Part B of Medicare

### Trip Fees for Clinical Laboratories (Section 8421, amending Section 1833(h)(3))

Current Law

- Nominal "trip fees", including transportation and personnel expenses, are paid for the collection of laboratory specimens from patients who are homebound or in nursing facilities. Most carriers have established trip fees based on average costs, or fee per mile, or a combination of the two methods.

Provision

- Requires the Secretary to provide a method for calculating trip fees based on the number of miles traveled and the personnel costs associated with the collection of each individual specimen. This method will apply to trip fees for tests performed between April 1, 1989, and December 31, 1990, but only for laboratories that establish to the satisfaction of the Secretary (based on data for the period beginning July 1, 1987 and ending June 30, 1988) that:

  - the laboratory was dependent upon Medicare payments for at least 80 percent of its collected revenues for clinical diagnostic testing;

  - at least 85 percent of gross revenues for laboratory tests were attributable to tests performed for patients who were homebound or in nursing facilities; and

  - the laboratory provided tests for residents in nursing facilities representing at least 20 percent of the facilities in the State in which the laboratory is located.

- Budget Neutrality - Requires the Secretary to make adjustments in the amounts paid for trip fees not covered under this amendment to ensure that the total payment of trip fees is the same as would have been without this amendment.

- Study - Requires the Secretary to study and report to Congress by May 1, 1989, on Medicare payment of trip fees. The study must include a survey of carrier reimbursement policies; report on the concerns of laboratories about such reimbursement; and make recommendations to assure reasonable

reimbursement that covers the costs involved and assures adequate access to clinical laboratory services for nursing facility patients.

Effective Date

- Upon enactment.

**Budget Neutrality Adjustment for Certified Registered Nurse Anesthetists (Section 8422, amending Section 1833(l)(3)(B))**

Current Law

- The Secretary must reduce the prevailing charges for the medical direction of CRNAs and/or the CRNA fee schedule as necessary to ensure that the estimated total amount (including coinsurance) that will be paid in 1989 and 1990 will not exceed the amount that would have been paid under the payment system in effect prior to 1989.

Provision

- Clarifies that in determining budget neutrality, applicable coinsurance must also be included in estimating the total payments under the pre-1989 system.

Effective Date

- As if enacted in OBRA 86 (October 21, 1986).

**Coverage of Psychologists' Services When Provided Off-Site as Part of a Treatment Plan (Section 8423, amending Section 1861 (ii))**

Current Law

- OBRA 87 provides for direct payment under the Medicare program for the services of a psychologist furnished at a community mental health center.

Provision

- Clarifies that psychologists' services furnished through a community mental health center are covered off-site if a patient is unable to get to the center because of physical or mental impairment or institutionalization. Off-site services provided in psychologists' offices are excluded from Medicare coverage.

Effective Date

- Applies to services furnished on or after January 1, 1989.

**Nonapplication of Certain Requirements to Physical Therapists (Section 8424, amending Section 1861(p))**

Current Law

- Medicare covers outpatient physical therapy services provided by a provider of services, clinic, rehabilitation agency, or physical therapist in his/her office or at the patient's home. The statute provides that the services are covered only when individuals are under the care of a physician, who establishes and periodically reviews a plan for furnishing the services. The regulations implementing the provision require that the entity furnishing the services must meet the requirements relating to physician care and to the establishment and review of the plan of care by a physician for all patients, not just Medicare patients.

- Some States have enacted physical therapy practice laws that allow a therapist to provide services independently, without a physician referral. However, because the Medicare requirements apply to all patients, the State laws have been, in effect, superseded by the Medicare requirements.

Provision

- The requirements for physician referral and a written plan of treatment established and reviewed by a physician are not applicable to the non-Medicare patients of a physical therapist.

Effective Date

- Applies to services provided after December 31, 1988.

**Functions of Physician Payment Review Commission (Section 8425, amending Section 1845(b)(2))**

Current Law

- The Physician Payment Review Commission (PPRC) was established by Congress to provide recommendations on Medicare physician payment policy. The law specifies eight areas for recommendation under the broad categories of:

  - adjustments to the reasonable charge levels for physicians' services, and

- changes in the methodology for determining the rates of payment and for making payment for physicians services and other items and services under the Medicare program.

Provision

o A ninth area for PPRC recommendation is added -- policies for moderating the rate of increase in expenditures and utilization of Medicare part B services.

Effective Date

o Effective with recommendations submitted in 1989.

**Moratorium on Laboratory Payment Demonstrations Extended (Section 8426)**

Current Law

o The Secretary is prohibited from using his authority to experiment with competitive bidding to purchase Medicare laboratory services until January 1, 1989.

Provision

o Extends the moratorium on laboratory competitive bidding demonstrations for an additional year, until January 1, 1990.

Effective Date

o Upon enactment

**Payment for Medical Escort or Medical Attendant on Commercial Airliner Allowed (Section 8427)**

Current Law

o Ambulance services on commercial airlines are covered under Medicare only:

  - for Medicare beneficiaries in Alaska;

  - when the medical condition of the patient requires immediate transfer to the nearest hospital;

  - when no ambulance service meeting the requirements for first aid equipment and first aid training of personnel is available within a reasonable distance from the area from which the patient is to be transferred; and

- all reasonable measures and available lifesaving equipment are used to insure the care and safety of the patient en route to the hospital.

Provision

- o Requires the Secretary to provide for a five-year period beginning July 1, 1989, during which Medicare will cover the medically necessary services of a medical escort or attendant when transportation on a commercial airliner is covered by Medicare as ambulance services.

Effective Date

- o Applies to payment for services furnished during the five-year period beginning July 1, 1989.

## Part IV - Provisions Relating to Medicaid

**Delay in Issuance of Final Regulations Concerning the Use of Voluntary Contributions and Provider-Paid Taxes by States to Receive Federal Matching Funds (Section 8431)**

Current Law

- o No Provision.

Provision

- o The Secretary is prohibited from issuing final regulations prior to May 1, 1989, changing the treatment of voluntary contributions or provider-paid taxes utilized by States to receive Federal matching funds under Medicaid.

Effective Date

- o Upon enactment.

**Medicaid Long-Term Care Waiver Program (Section 8432, amending Section 1915(d)(5)(B))**

Current Law

- o States may provide home or community-based services to individuals age 65 and older who would otherwise require institutionalization. States must use the prescribed formula, with prescribed indices and annual increases, to determine the maximums they may spend on nursing facility (NF) services and home and community-based services (HCBS).

Provision

- Allows a modification of a State's limit on expenditures under a home and community-based waiver to adjust for increased projected expenditures if any statute is enacted subsequent to OBRA 87 ( December 22, 1987) which increases the aggregate amount of medical assistance for NFs and HCBS for individuals age 65 and older. The Secretary, at the request of a State, will adjust the projected expenditures computed under this provision for the affected waiver year(s).

Effective Date

- For waiver years beginning during or after FY 1989.

**Extension of Time Period for Submission of Correction and Reduction Plans for Certain Intermediate Care Facilities for the Mentally Retarded (Section 8433, amending Section 1922)**

Current Law

- Facilities with planned reductions of beds may use correction and reduction plans to remedy deficiencies for physical plant, staffing, and other minor deficiencies which do not pose an immediate threat to the health and safety of ICF/MR residents.

- This provision applies only to plans approved by the Secretary by April 7, 1989, which is three years after the effective date of the final implementing regulations.

Provision

- Clarifies that correction and reduction plans may also be used to remedy deficiencies related to active treatment, and requires the State, in approving these plans, to specify how active treatment will continue to be provided during the time that the approved plan is in effect.

- Extends the application of this provision to plans approved by January 1, 1990.

Effective Date

- Upon enactment. Shall apply to any administrative proceeding where there has not yet been a final determination by the Secretary as of the date of enactment.

**Correction Relating to Medicare Buy-In (Section 8434, amending Section 1905(p)(1))**

Current Law

- The criteria used to determine a "qualified Medicare beneficiary" (QMB); that is, an individual for whom Medicaid pays Medicare premium, deductible and coinsurance amounts, is that the individual:

  - be entitled to Medicare;
  - not be otherwise eligible for Medicaid; and
  - have income below the Federal poverty line.

Provision

- The QMB prohibition on being otherwise ineligible for Medicaid is removed. For example, an individual may receive benefits as both medically needy and as a QMB.

Effective Date

- As if included in the Medicare Catastrophic Coverage Act of 1988 (July 1, 1988).

**Clarification of Federal Financial Participation for Case Management Services (Section 8435, amending Section 1915(g)(2))**

Current Law

- States may provide case management services which assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services.

Provision

- The Secretary may not refuse approval of a State plan amendment or deny a State payment for case management services on the basis that:

  - State law requires the State to provide such services, or

  - the State is paying or has paid for case management services from non-Federal funds before or after April 7, 1986.

  However, the Secretary is not required to pay States for case management services provided without charge to the users.

Effective Date

- Upon enactment.

**Determination of Premium Amounts for Extended Medical Assistance (Section 8436, amending Section 1925(d)(5)(C))**

Current Law

- The premium for Medicaid benefits extended during a second six-month period to those who have lost AFDC eligibility cannot exceed three percent of the family's average gross monthly earnings during the base period.

Provision

- Clarifies that the premium cannot exceed three percent of the family's average gross monthly earnings less the average monthly costs for child care necessary to accommodate the caretaker relative's employment.

Effective Date

- As if included in the Family Support Act of 1988 (October 12, 1988).

**Clarification of Waiver for Home and Community-Based Services for Individuals who would Otherwise Require Hospital or Facility Care (Section 8437, amending Section 1915(c)(7)(A))**

Current Law

- Illness or condition-specific waivers (e.g., AIDS, ventilator dependency) require that an individual must have been an inpatient in a hospital, NF, or ICF/MR prior to receiving HCBS.

Provision

- Removes the requirement for institutionalization prior to receiving HCBS under an illness or condition-specific waiver.

Effective Date

- Effective for all pending and future waiver applications.